Gynuity HEALTH PROJECTS

FREQUENTLY ASKED QUESTIONS

ULIPRISTAL ACETATE: A POTENTIAL NEW REGIMEN FOR MEDICATION ABORTION

In January 2025, the peer-reviewed journal, *New England Journal of Medicine Evidence*, published the results from a proof-of-concept study establishing the potential of ulipristal acetate for early medication abortion. We have compiled this list of frequently asked questions about our initial clinical research into ulipristal acetate for this new purpose.

Why undertake clinical research into a new medication abortion regimen?

Abortion is an essential part of reproductive health care and can be achieved with an abortion procedure, such as vacuum aspiration, or medication. Medication abortion with mifepristone and misoprostol is safe and highly effective (see here), but access to mifepristone in many countries is limited. Evidence is needed to show that another medicine used together with misoprostol can serve as a viable alternative.

What would be the benefit of a new regimen?

Increasing options for medication abortion could have positive implications for health systems across all resource levels and allow a greater number of women, adolescent girls and other persons capable of pregnancy to access safe and high-quality abortion care.

Why was ulipristal acetate (UPA) identified as a possible substitute for mifepristone?

UPA has a similar chemical compound and mechanism of action to mifepristone, acting as a selective progesterone receptor modulator, and is rapidly absorbed when taken orally. It is marketed as a 30 mg tablet for use as an emergency contraceptive and available either by prescription or over the counter in many countries. Our research does not negate UPA's other uses.

What regimen did you use for the proof-of-concept study?

A single dose of 60 mg oral UPA followed by 800 mcg buccal misoprostol 24 hours later.

What did the study involve?

We conducted an open-label study to evaluate the efficacy and acceptability of an ulipristal acetate–misoprostol abortion regimen among participants with pregnancies through 63 days of gestation. The study was implemented in two stages between August 2022 and September 2023 at the outpatient clinic of a public maternal hospital in Mexico City.

Stage 1 Sixty-six women presenting at the clinic for a medication abortion were enrolled and randomly assigned to either 60 mg or 90 mg of oral UPA prior to misoprostol. The two groups, each comprised of 33 participants, in the preparatory dose-finding study showed similar efficacy and safety profiles.

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Stage 2 An additional 100 abortion patients were then enrolled to supplement the 33 participants who received the 60 mg UPA dose, resulting in a total of 133 participants analyzed.

The participants returned to the clinic around two weeks later for a follow-up assessment, including an ultrasound to determine pregnancy status and a structured questionnaire to evaluate participants' satisfaction with the regimen and willingness to recommend the method to others.

What were the inclusion criteria for participant selection?

- ✓ Intrauterine pregnancies ≤63 days' gestational age
- ✓ Body mass index ≤32 kg/m2
- ✓ ≥18 years of age or emancipated minors
- ✓ Residents of Mexico City
- ✓ Willingness to take part in an exit interview

Why did you include body mass index (BMI) as an eligibility criterion?

Data from previous randomized trials have shown that a high BMI may be associated with a higher failure of UPA in emergency contraception.

What was the most common gestational age range at the time of enrollment?

Women were eligible to take part in our study if they had an intrauterine pregnancy through 63 days' gestation, confirmed by ultrasound on the day of UPA administration. Most pregnancies fell between the gestational age range of 43 and 56 days.

Was the study regimen effective?

The study regimen showed a high success rate. Complete abortion was confirmed by ultrasound at the follow-up visit in 129 out of 133 participants (97%; 95% confidence interval, 94.1 to 99.9%).

Was additional care necessary after treatment with the study medications?

There was minimal need for additional care. Four participants underwent additional interventions for incomplete abortion (n=1) or ongoing pregnancy (n=3): one had an emergency room visit and completion with sharp curettage, two received a manual vacuum aspiration, and one underwent a repeat medication abortion with misoprostol alone. Further care was provided to three other participants: one received antibiotics due to a urinary tract infection and, following misoprostol, one received pain medication after almost fainting from pain and another antihistamine for a mild allergic reaction.

Were there any deaths or serious adverse events?

No.

What side effects did participants report experiencing after taking the study medications?

After administration of UPA, side effects were either absent or infrequent, occurring in less than 4% of participants. Self-reported side effects after UPA included chills, nausea, headache, mild pelvic pain, and mild tinnitus. After administration of misoprostol, the most common side effects reported were chills, diarrhea and nausea. These types of side effects are transitory, easily managed, and often associated with misoprostol use.

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Were participants satisfied with the study regimen?

To evaluate acceptability, participants took part in an exit interview. Overall satisfaction was high, with 130 out of 133 participants rating the treatment as satisfactory or very satisfactory (97.7%). Among the 133 participants questioned, 113 rated the pain level as acceptable or very acceptable and an additional 9 as neutral, 121 said they would recommend the regimen, and 120 said they would choose these medications in a future abortion.

What are the implications of the proof-of-concept study?

The study findings provide evidence for the usefulness of ulipristal acetate as a new combination therapy with misoprostol to achieve early pregnancy termination safely and effectively. The promising results justify further investigation.

Where can I read the published paper?

The paper resulting from our proof-of-concept study was subject to an independent peer-review process before publication in a scientific journal. Read abstract: A proof-of-concept study of ulipristal acetate for early medication abortion Winikoff B, Bousiéguez M, Salmerón J, Robles-Rivera K, Hernández-Salazar S, Martínez-Huitrón A, García-Martínez LM, Aguirre-Antonio L, Dzuba IG; NEJM Evid 2025;4(2); Read in full: 10.1056/EVIDoa2400209

Are you planning to carry out further clinical research into UPA for medication abortion?

We are conducting another study in Mexico to validate the best regimen using the least amount of UPA for the best outcomes. We expect enrolment for this placebo-controlled randomized trial to be complete in 2026. We envision then bringing this research to more countries to collect comprehensive data on the safety, effectiveness, and acceptability of UPA for medication abortion among different populations. The findings from the study currently underway will inform the design of the larger multi-country trial.

What do you say to those who are fearful that UPA could be targeted by anti-abortion activists and legislation?

There is nothing new in the opposition of anti-abortion groups to all forms of modern contraception. A piece by the founder and host of Feminism Makes Us Smarter addresses some of the concerns. See here.

Has UPA been tested previously among patients seeking abortion?

Colleagues have studied UPA use, as an alternative to mifepristone, for cervical preparation in second trimester abortions prior to dilation and evacuation. See here and here. We are also aware of another study that is exploring UPA for use in early pregnancy loss. See here.

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Would use of UPA for medication abortion be considered off-label?

Yes. The use of approved drugs for unlabeled indications is common practice and not considered experimental if based on sound scientific evidence. For instance, misoprostol is approved for preventing and treating gastric ulcers but has been extensively studied, including by Gynuity Health Projects, in reproductive health and is widely used off-label safely and effectively for multiple obstetric and gynecologic indications.

Can misoprostol-only regimens be used for medication abortion?

Regimens that include misoprostol alone are a reasonable alternative when access to mifepristone is not feasible. Compared to mifepristone-misoprostol regimens, treatment with misoprostol alone may take longer and pain may last longer, and there is an increased likelihood of continuing pregnancy. Read more here.

About Gynuity Health Projects

Gynuity Health Projects is a non-profit organization founded in 2003 that is dedicated to making high-quality reproductive and maternal health technologies more widely available at reasonable cost. Through research and strategic partnerships, we create new knowledge and insights to foster evidence-based decision-making, clinical guideline development, and program implementation. Evidence from Gynuity's research has helped shape national/global policies and guidelines on medication abortion, including self-care approaches, as well as on the management of postpartum hemorrhage with misoprostol.

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